

Oregon Health Policy Board

AGENDA

May 24, 2012

Planning Session

[Keizer Heritage Center](#)

980 Chemawa Rd. NE. Keizer, Oregon 97307

9:00 a.m. to 3:00 p.m.

Goals

- Determine Oregon Health Policy Board work plan and priorities for the coming year
- Ensure the board is working effectively to realize its goals

#	Time	Item	Presenter	Action Item
1	9:00	Welcome, call to order and roll call Consent agenda: 4/10/12 minutes	Chair	X
2	9:05	Agenda overview and goals	Diana Bianco	
3	9:10	Review of OHPB's founding agreements	Diana Bianco	
4	9:15	Board role <ul style="list-style-type: none">• Interview summary• Discussion	Diana Bianco	
	10:15	Break		
5	10:30	Where we've been; where we're going <ul style="list-style-type: none">• Accomplishments• Action Plan review	Bruce Goldberg Tina Edlund	
6	11:30	Work plan priorities for the coming year <ul style="list-style-type: none">• Interview summary• Staff input• Discussion	Diana Bianco	
	12:30	Lunch		
7	1:30	Work plan priorities for the coming year (cont'd) <ul style="list-style-type: none">• Discussion	Diana Bianco	
8	2:30	Summary and next steps	Diana Bianco	
9	2:45	Public Comment	Chair	
10	3:00	Adjourn	Chair	

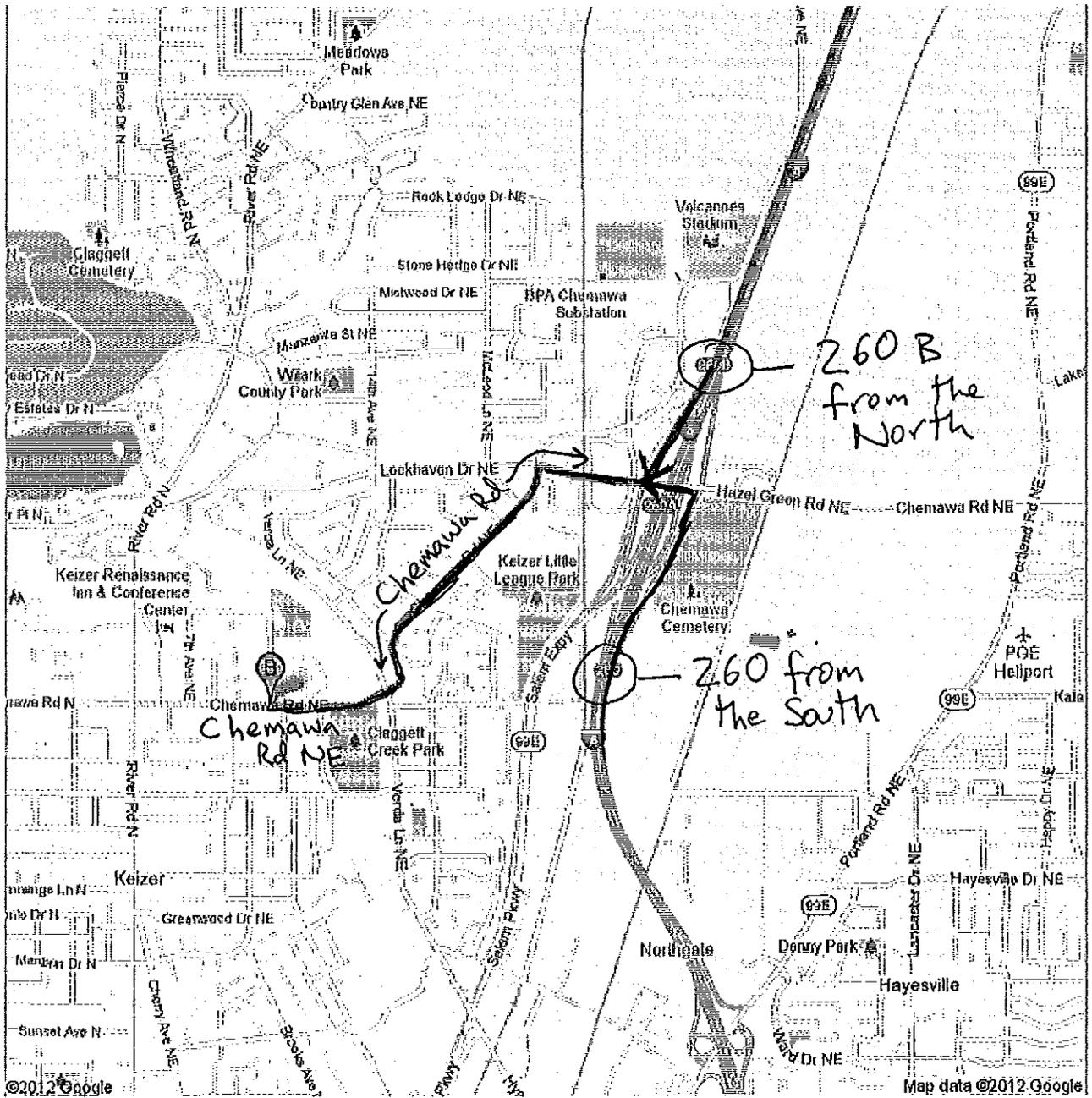
Next Meeting:
June 12, 2012
Market Square Bldg.
1 p.m. to 5 p.m.



Directions to Keizer Heritage Community Center

980 Chemawa Road Northeast, Keizer, OR 97303 - (503) 393-9660

43.1 mi - about 1 hour 1 min



Oregon Health Policy Board

DRAFT Minutes

April 10, 2012

1 p.m. to 2:30 p.m.

[Webinar](#)

Item
<p>Welcome and Call To Order</p> <p>Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present.</p> <p>Bruce Goldberg and Tina Edlund were present from the Oregon Health Authority (OHA).</p>
<p>Consent Agenda:</p> <p>The minutes from the March 13, 2012 meeting were unanimously approved.</p>
<p>Director's Report – Bruce Goldberg</p> <p>Bruce Goldberg gave an update regarding the Centers for Medicare and Medicaid Services (CMS) and spoke about the Oregon Health Insurance Exchange (ORHIX.) Goldberg said the OHA has been focused on implementation of Coordinated Care Organizations (CCOs) and working with CMS over the past few month months. OHA is working with CMS for approval of its 1115 waiver as well as approval of funding to help capitalize transformation. Goldberg said he hopes to wrap up funding negotiations in the near future. Goldberg also said ORHIX presented a business plan to the legislature that was approved and has been working on contracting and its website.</p> <p><i>The Director's Report can be found here, starting on page 5.</i></p>
<p>CCO Implementation – Judy Mohr Peterson, Patty Wentz</p> <p>Judy Mohr Peterson gave an update on the CCO Implementation process. She spoke about timelines, letters of intent, next steps in the procurement process, the rules process, and OHA's internal implementation. Mohr Peterson said OHA received 47 letters of intent, which cover every area in the state. Mohr Peterson also described the internal implementation process which is structured in several workstreams, including waiver, procurement, finance, member transition, delivery system transition, community development and readiness, operations, Medicare and Medicaid alignment, quality and accountability, communications, information systems, and health analytics.</p> <p>Patty Wentz spoke about the CCO Implementation communication plan, including applicant webinars and specific communications requirements during the Request for Applications process.</p> <p><i>A matrix of CCO Letters of Intent to Apply can be found here, starting on page 7.</i></p>
<p>Update on Essential Health Benefit Workgroup – Jeanene Smith</p> <p>Jeanene Smith gave an update on the Essential Health Benefit Workgroup. Governor's office announced on April 2 workgroup members, which includes representatives from major commercial health plans, insurance agents, mental health care, dental care, counties, consumers, small business owners, and liaisons from the OHPB and ORHIX boards. Smith said the first meeting will be on April 16 and draft recommendations will be completed by July.</p>
<p>OHPB Strategy Session – Tina Edlund</p> <p>Tina Edlund spoke about the upcoming OHPB strategy session. She said it will be a full-day meeting and it will take place in district. Edlund also said Diana Bianco will be acting as facilitator.</p>
<p>Adjourn</p>

Next meeting:

OHPB Planning Session

May 24, 2012

9 a.m. to 3 p.m.

Keizer Heritage Center

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OREGON HEALTH POLICY BOARD
Policy-Making and Oversight Role

The Oregon Health Policy Board is the policy-making and oversight body for the Oregon Health Authority. § 9(1) HB 2009.

- **Policy-making:** Recommending desired objectives or proposed actions from among alternatives in the light of given conditions to guide present and future decisions.
 - Related to the topics identified by the Legislature in HB 2009
 - access to affordable, quality health care for all Oregonians by 2015
 - uniform, statewide health care quality standards
 - evidence-based clinical standards and practice guidelines
 - cost containment mechanisms
 - health care workforce
 - comprehensive health reform
 - health benefit package
 - health insurance exchange
(not a complete list)
 - Sheer scope and magnitude of these topics shows that Board involvement is to evaluate, review, adopt, and promote alternatives in order to make necessary reports and recommendations to the Oregon Health Authority and, as appropriate, the Legislative Assembly.
 - Board is aided in its functions:
 - Committees
 - Oregon Health Authority
- Administration and implementation is assigned to the Oregon Health Authority, in addition to their other duties and functions.*
- **Oversight:** Evaluating progress toward achieving policy objectives. It may also include re-evaluating policy in light of additional information or changed circumstances (e.g., changes in federal law, etc.).
- Actual implementation of certain policy objectives may require legislative approval or funding.

*Final policy-making authority for OHA as the state Medicaid agency must be retained by OHA to meet federal requirements.

**Oregon Health Policy Board
Decision making Process
December 2009**

The Oregon Health Policy Board will make numerous decisions as it seeks to improve the health of all Oregonians. To ensure our decision making is effective and has integrity, we have agreed on the following principles to inform our decision making process.

- Discussion and communication preceding a decision is critical. We will ensure that each member has the same information and that we have robust and open discussions where all opinions are heard and valued.
- As we make decisions, each member will have the opportunity and obligation to participate in discussions.
- In all discussions, we will be respectful in our communication with each other.
- We all have a responsibility to “take the group temperature” as we have discussions and reach decision points.
- We will strive to seek consensus on all of our decisions. When we cannot reach consensus, the Chair will have the prerogative to decide how we will move forward. Options include a majority vote, tabling the decision, or gathering more information and revisiting the discussion at a later time.
- When a board member agrees to a decision, they have concluded that “this is the best decision this group can collectively make and once we make the decision, I will support it 100%.”
- If the board is unable to achieve consensus, those who disagree should clearly articulate concerns and try to offer alternatives.
- Once the board makes a decision, each member shall fully support the decision.

Oregon's Action Plan for Health, 2010: Status of Action Items

Action Items

Action	Status
Set a target for health care spending in Oregon	Through Health System Transformation (SB1580), Coordinated Care Organizations (CCOs) will operate on a global budget that will increase at a fixed rate not tied to increases in medical costs.
Align purchasing: <ul style="list-style-type: none"> • Standardize certain provider payments to Medicare methodology to set stage for future payment reform. • Focus on quality and cost improvement efforts to achieve critical momentum. • Introduce innovative payment methods that reward efficiency and outcomes. 	<p>Senate Bill 204 required the state to develop and implement standardized alternative payment methodologies for hospital services for all state purchased insurance (PEBB, OEBC, Medicaid). A work group met three times in late 2011 and made recommendations on standardized payments. The methodology has been implemented in most parts of the state.</p> <p>CCOs will have the flexibility to offer innovative payment methods that will reward providers for health outcomes, both on a patient level and/or a population level. CCOs will also partner with local Patient-Centered Primary Care Homes (PCPCH). PCPCHs will receive payment incentives for keeping patients healthy. The PCPCH Program is working toward a system that provides additional supports to recognized primary care homes for their commitment to patient-centered care, allowing them to focus on prevention and better management of chronic conditions. Recognized primary care homes can apply to receive additional Medicaid funding to support the comprehensive, coordinated and patient-centered care they offer Medicaid patients with chronic conditions such as diabetes and asthma.</p>
Reduce administrative costs in health care	OHA is working with CCOs and with representatives from the Centers for Medicare and Medicaid Services to find ways to reduce administrative red tape and burdens that weigh down the system by creating inefficiencies.

Action	Status
	<p>The legislature passed SB 94 in 2011 which expanded some of the recommendations from the Administrative Simplification work group and allows DCBS to create uniform standards for administrative aspects of health insurance and care. OHA, through a partnership with the Health Leadership Council (HLC), has been working to implement these recommendations and has now completed companion guides on uniform standards for Eligibility Transactions (270/271) and Claims and Encounter Transactions (837); both mandated to be effective this year. A centralized portal for common credentialing is also being considered by the HLC at this time.</p> <p>OHA is also working to implement reductions to administrative burdens identified through Health Systems Transformation work. Specific work related to these burdens that are also part of SB 94 and SB 238 (2011), which required the Addictions and Mental Health Division to revise rules related to administrative burdens on providers, are being incorporated into streamlining work and efficiencies.</p>
Decrease obesity and tobacco use	<p>Obesity and tobacco are identified as priorities in the recently released Public Health strategic plan. Public health and partners are meeting May 14-23, 2012 to identify targets and strategies to move all of the public health priority areas forward, including obesity and tobacco. Like tobacco, the most effective strategies to reduce obesity involve changing the social and physical environment.</p> <p>OHA is continuing to make significant progress around tobacco, including toward tobacco-free state properties, reducing tobacco use among state employees through the health engagement model and cessation services, supporting tribal casinos in going smoke-free, and engaging in a social marketing campaign to warn</p>

Action	Status
	<p>the public about the risks of tobacco use.</p> <p>Obesity and overweight continues to be a significant challenge for the State. Although there is currently no funding for an obesity prevention program, positive steps are being taken. On May 15, OHA released a report on the significance of the obesity epidemic in Oregon. Evidence-based approaches to changing the social and physical environment, such as ensuring healthy food options and altering the information environment, continue to be the best way to prevent and reduce overweight and obesity.</p> <p>Public Health Division plans to work with the CCOs to encourage the adoption of evidence-based approaches to prevention and health promotion, and will provide technical assistance around CCO metrics related to tobacco use and obesity/overweight.</p> <p>The Public Health Division will continue to monitor tobacco use and obesity/overweight among all Oregonians to evaluate the effectiveness of our efforts.</p>
<p>Establish a mission-driven public corporation to serve as the legal entity for the Oregon Health Insurance Exchange</p>	<p>SB 99 established the Oregon Health Insurance Exchange Corporation in 2011. Created as a public corporation and governed by a 9-member Board of Directors who are appointed by the Governor and confirmed by the Senate, the Exchange's mission is many-fold: advance the Triple Aim in Oregon; administer the exchange in the public interest that is accountable to the public; empower Oregonians by providing information and tools to make smart health insurance choices; improve health care quality and mitigate health disparities; and encourage innovative health insurance products. In February 2012, the Legislature approved the Corporation's Business Plan as required in SB 99.</p>

Action	Status
	<p>The Corporation has hired an Executive Director and several other key staff; developed its own infrastructure; applied for and received federal grants that fund the planning, implementation and operational activities of the Exchange; and has established the policy and functional framework for all aspects of Exchange operations, including working with the OHA to develop the IT systems and Exchange web portal.</p>
<p>Promote local and regional accountability for health and health care</p>	<p>CCOs will operate on a local and regional level and will be accountable for the health of the entire population they serve. Each CCO will be responsible for performing a community health assessment and for finding ways to help improve the overall population health of the region they serve.</p> <p>At the same time, CCOs will utilize innovator agents that will help them collaborate statewide on best practices and innovations.</p>
<p>Build the health care workforce</p> <ul style="list-style-type: none"> • Use loan repayment to attract and retain primary care providers in rural and underserved areas • Standardize prerequisites for clinical training via a student “passport” • Extend requirement to participate in Oregon’s health care workforce database to all health professional licensing boards. 	<p>The Workforce Committee heard presentations on loan repayment and their estimated impact on recruitment and retention. Primary Care Office (PCO) staff is working to maximize the number of awards that can be made to Oregon clinicians and scholars. Additionally, PCO is administering a federal grant to retain National Health service Core (NHSC) clinicians in underserved areas who are currently taking advantage of Loan Repayment.</p> <p>As part of the state’s agreement with the Centers for Medicare and Medicaid Services (CMS) for significant federal investment through matching Designated State Health Programs (DSHP), the state will reinvest in a loan repayment program and train more Community Health Workers.</p> <p>April concluded the third meeting of a stakeholder work group convened through SB 879 (2011). The work group made draft recommendations on how to create a more efficient system by standardizing administrative requirements for student</p>

Action	Status
	<p>clinical placements. The recommendations included:</p> <ol style="list-style-type: none"> 1. Standards that address immunization, training, drug screening, background checks, and other (liability, health insurance, etc.). 2. Articulating the standards in administrative rule by OHA. The effective date of the rules should be far enough in the future that training programs and clinical sites have time to amend contracts as needed. 3. Some type of student “passport” that will allow for easy tracking of students’ standings. <p>Next step is to vet recommendations around widely, in particular get buy-in from leadership of organizations that will be affected. A report was delivered to the legislature May 21, 22 during interim legislative committee hearings. A final report to the legislature will be sent by the end of June.</p> <p>In the fall of 2011, OHPR met with three new licensing boards in preparation for including their data in the Oregon Healthcare Workforce Database: the Board of Licensed Professional Social Workers; the Board of Professional Counselors and Therapists; and the Board of Psychologist Examiners. HB 3650 directed OHA to expand the database but does not compel new boards to make participation a requirement for licensure; OHPR will assess the response rate with voluntary participation. As of January 2012, the Board of Licensed Clinical Social Workers and Board of Professional Counselors and Therapists will begin participating in the healthcare workforce database this spring (on a voluntary basis). The Board of Psychologists Examiners is interested but cannot commit at this time due to staffing shortages. More and more of the 7 original boards are choosing to use a centralized online questionnaire developed by OHPR, rather than embedding the required workforce items into their own systems, which should increase the comparability and timeliness of the data.</p>

Action	Status
<p>Move to patient-centered primary care (PCPCH), first for OHA lives (Medicaid, state employees, educators) and then statewide</p>	<p>As of May 2012, over 150 practices statewide have been recognized by the OHA as Patient-Centered Primary Care Homes (PCPCH).</p> <p>The Division of Medical Assistance Programs received approval from CMS in March 2012 to provide enhanced payments to recognized PCPCH practices for Medicaid clients meeting certain criteria. Payments are anticipated to begin flowing to clinics in June 2012. Once payment begins, an update on number of covered lives receiving care through a PCPCH will be available.</p> <p>Similar payment structures for PEBB and OEBC lives are under discussion. Contract language requiring PEBB and OEBC insurance carriers to provide enhanced payments to recognized PCPCH practices for PEBB and OEBC covered lives is anticipated to be in place October 2012.</p> <p>OHA, in partnership with the Northwest Health Foundation, is creating the Center for PCPCH Technical Assistance. The Center will provide resources through a variety of strategies to assist clinics with practice transformation and achieving the PCPCH standards. A request for proposals for an entity to lead this work recently closed. The successful proposal will be announced by June 2012.</p>
<p>Introduce a value-based benefit design that removes barriers to preventive care.</p>	<p>There have been 20 value-based services representing preventive care and chronic disease management identified by the Health Services Commission. The set has highest evidence of clinical and cost-effectiveness for which little or no cost-sharing should be required. Please see attached document for a full list of the highlighted value-based services.</p> <p>A value-based benefit design prototype is available, using the Prioritized List of Health Services and the 20 sets of value-based services available with model pricing. It uses four tiers of cost-sharing which increase for services prioritized</p>

Action	Status
	lower on the list. Some elements of the fourth tier are used in PEBB's current (2012) benefit design.
Expand the use of health information technology (HIT) and exchange (HIE)	<p>Oregon's Health IT Extension Center (O-HITEC) measures progress in achieving electronic health record (EHR) adoption and meaningful use by Oregon providers in terms of three progressive Milestones for the federally-set target of 2,674 Priority Primary Care Providers (PPCPs)::</p> <ul style="list-style-type: none"> • Milestone 1 (PPCP membership)- currently have 3,016 members, 113% of target • Milestone 2 (Go Live) – currently 1,962 PPCPs have achieved this milestone (73%), above the projected figure for June 2012 of 60% • Milestone 3 (Meaningful Use) – pending meaningful attestations bring the figure to 28% of target PPCPs, near the projected figure for June 2012 of 30% <p>Incentives for the adoption and meaningful use of EHRs are being paid through federally run Incentive Programs for Medicare, and by states for Medicaid. Oregon's Medicaid EHR Incentive Program launched in September 2011. As of May 3rd, 2012 that program has delivered the following incentive payments (federal dollars) to Oregon providers:</p> <ul style="list-style-type: none"> • 609 Eligible Professionals have received a total of \$12,679,179 • 35 Eligible Hospitals have received a total of \$25,065,341 <p>CareAccord statewide health information exchange (HIE) services launched in April, 2012, offering web-based secure Direct Messaging Services to any provider regardless of whether they have an EHR system or not. Phase One services are available at no cost, Phase Two services will include additional functionality as per market demand. Regional Health Information Organizations continue to develop services that their local markets will support.</p>

Action	Status
	<p>Oregon’s Health Information Technology Oversight Council (HITOC) is developing Oregon’s Strategic Plan for Health IT that will offer policy recommendations for continued steps to expand the use of HIT and HIE.</p>
<p>Develop guidelines for clinical best practices</p>	<p>Health Evidence Review Commission (HERC) created in January 2012, assuming the Prioritized List work of the Health Services Commission and the health technology review work of the Health Resources Commission. HERC will provide evidence-based guidance to public and private purchasers on coverage of health care services with high cost, high utilization and/or high variation in provider practice.</p> <p>Two guidelines approved by HSC/HERC so far:</p> <ul style="list-style-type: none"> • Evaluation and management of low back pain (includes pharmacologic and non-pharmacologic, non-invasive treatments) • Advanced imaging for low back pain <p>One guideline completed and awaiting HERC consideration on 6/14/12:</p> <ul style="list-style-type: none"> • Percutaneous interventions for low back pain <p>20 “coverage guidances” to be complete by end of 2012 (8 awaiting HERC consideration on 6/14/12).</p>
<p>Strengthen medical liability system</p> <ul style="list-style-type: none"> • Remove barriers to full disclosure of adverse events by providers and facilities • Clarify that statements of regret or apology may not be used to prove negligence 	<p>Senate Bill 1580 established the work group on Patient Safety and Defensive Medicine that will recommend legislation to be introduced during the 2013 regular session.</p> <p>The work group will focus on legislation that</p> <ul style="list-style-type: none"> • Improves patient safety • More effectively compensates individuals who are injured as a result of

Action	Status
	<p>medical errors, and</p> <ul style="list-style-type: none"> • Reduces collateral costs associated with the medical liability system.
Performance measurement	<p>Based on the initial work of the Board's Incentives and Outcomes committee, there has been further development of metrics through the health system transformation workgroup process and included in the implementation plan for CCOs. The CCOs will be accountable based on metrics, and SB 1580 set up an ongoing Metrics and Scoring Committee to continue this work. A transitional Metrics and Scoring Committee was established by OHA Director Bruce Goldberg and held its first meeting on March 15, 2012. The transition committee endorsed a set of core metrics to be included in CCO contracts for the first contract year.</p> <p>CMS will include terms and conditions for accountability, including metrics and transparency requirements, as part of the 1115 waiver request.</p> <p>Performance measurement will be a critical aspect of CCOs, as payment methodology evolves to reward providers for health outcomes rather than discrete services.</p>

“The Future”

Vision	Status
<p>A coordinated and regionally integrated health system in which incentives are aligned toward quality care for every Oregonian.</p>	<p>Health System Transformation (HB 1580) established a system for delivering Medicaid that will help coordinate care for patients at a local level. CCOs will be paid through a global budget that will create incentives for providers to keep their patients healthy and out of the hospital, creating better and more affordable health care.</p> <p>CCOs will operate on a local/regional level, where they can cater services to a specific population with specific needs. Each CCO will have a governing board that includes financial stakeholders, physicians, and community members. CCOs also must have Community Advisory Councils (CACs) to help ensure that the health care needs to the consumers and the community are being met.</p>
<p>A holistic approach that focuses on the patient, not the symptoms, and emphasizes preventive care and health lifestyles.</p>	<p>CCOs will have incentives and be accountable for providing health to patients in a holistic manner. They will be responsible for a patient’s physical, mental, and oral health care (starting in 2014). Prevention will be key in keeping patients healthy and out of the emergency room. Many CCOs might take an approach that includes community health workers, who will be charged with building relationships with high use patients and ensuring that those patients are receiving patient centered, holistic, preventative care, as well as taking medications on time and routinely visiting their primary care doctor.</p> <p>CCOs must also conduct regular Community Health Assessments (overseen by the CAC) to determine where the greatest needs for services are, what measures and programs can be implemented to provide better overall health, and where general improvements in the community’s health and health systems could be made.</p>

Vision	Status
A community-based team of health care professionals, not just doctors, will help keep people healthy and treat them when they are sick	CCOs will offer patients a team-based approach to health that will include providers of different types. Behavioral therapists, community health workers, nurse practitioners, chiropractors, primary care doctors, and more can all be involved in a patient’s health care. That will ensure that patients are receiving the right care, at the right time, in the right place.
Providers get paid for keeping people healthy.	CCOs will be paid a global budget and will be responsible for maintaining the health of the entire population they serve. The goal is to eventually have all Medicaid members receive care through a CCO that is responsible for keeping the person healthy. Performance measurement will include measures of population health as well as health care and efficiency metrics.
Private, secure electronic medical records help providers see their patients’ complete health picture and know what tests have already been done.	<p>Currently, Oregon is exceeding its goals for adoption of Electronic Health Records (see above section on expanding the use of HIS for more details). Incentives for the adoption and meaningful use of EHRs are being paid through federally run incentive programs for Medicare and by states for Medicaid. Oregon’s Medicaid EHR Incentive Program launched in September 2011.</p> <p>We are currently addressing the issue of offering providers a “complete health picture” (a provider having access to all of a patient’s health-related data, such as claims, clinical, demographic, etc.) in Oregon’s Strategic Plan for HIT.</p>
A highly efficient health care system	<p>OHA is working with CCOs and with representatives from the Centers for Medicare and Medicaid Services to find ways to reduce administrative red tape and burdens that weigh down the system by creating inefficiencies.</p> <p>The legislature passed SB 94 in 2011 which expanded some of the recommendations from the Administrative Simplification work group and allows DCBS to create uniform standards for administrative aspects of health insurance and care. OHA, through a partnership with the Health Leadership Council (HLC), has been working to implement these recommendations and has now</p>

Vision	Status
	<p>completed companion guides on uniform standards for Eligibility Transactions (270/271) and Claims and Encounter Transactions (837); both mandated to be effective this year. A centralized portal for common credentialing is also being considered by the HLC at this time.</p> <p>OHA is also working to implement reductions to administrative burdens identified through Health Systems Transformation work. Specific work related to these burdens that are also part of SB 94 and SB 238 (2011), which required the Addictions and Mental Health Division to revise rules related to administrative burdens on providers, are being incorporated into streamlining work and efficiencies.</p>
<p>Together, clinical and public health providers will be accountable for the health of the whole community.</p>	<p>OHA is implementing CCOs which will be held accountable for outcomes. One requirement for CCOs will be to collaborate with the community to develop a community health assessment that considers the health of the entire community.</p> <p>The Public Health Division of OHA has announced plans to pursue national accreditation, and has developed a strategic plan, statewide community health assessment, and a statewide community health improvement plan focused on health outcomes.</p> <p>Local public health authorities are being supported by Public Health Division, as a part of a public health system transformation initiative, in their pursuit of accreditation, When performing Community Health Assessments, CCOs will partner with local health care systems and local public health to determine where the greatest needs for services are, what measures and programs can be implemented to provide better overall health, and where general improvements in the community's health and health systems could be made.</p>

Vision	Status
<p>As more people get health insurance coverage, public health systems will devote more time and resources to maintaining healthy populations.</p>	<p>OHA's Public Health Division has announced a reorganization and strategic plan to refocus its work on the community-based health improvement opportunities, and will continue to support clinical health services where those are essential to the health of the population.</p> <p>Public Health Division and other parts of OHA are working together with federal partners to identify opportunities to integrate community prevention activities into healthcare transformation efforts within CCOs.</p> <p>Public Health Division has developed and is starting to implement an initiative to support local public health authorities in their transition to help prepare for the shift in the focus of activities, when all people are covered. Regular Community Health Assessments, performed in collaboration with local public health, will allow innovations and improvements to occur often. These assessments will allow CCOs to track where progress is being made, both on an individual and community level. Where programs are working on a population scale, more resources can be diverted to those programs to help improve the overall health of the population.</p>

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Value-Based Services

Proposed “Barrier-Free” services for use within a value-based benefit package

Diagnosis	Medications	Labs	Imaging/Ancillary	Other
Asthma	Medications according to NICE 2008 stepwise treatment protocol	None	Diagnostic spirometry	None
Bipolar Disorder	Lithium, valproate	Lithium – lithium level (q3 months); creatinine and TSH (q6 months) Valproate -LFTs and CBC (q6 months)	None	Medication management
Cancer Screening	None	Pap smears Fecal occult blood testing	Mammography Colonoscopy/Flexible sigmoidoscopy	Per USPSTF recommendations, “A” and “B” recommendations only
Chemical Dependency Treatment	Buprenorphine for opioid dependence Acamprosate for alcohol dependence	None	None	Brief behavioral intervention to reduce hazardous drinking (SBIRT) Methadone maintenance treatment
Chronic Obstructive Pulmonary Disease(COPD)	Short-acting inhaled bronchodilator	None	None	None
Congestive Heart Failure (CHF)	Beta-blockers, ACE inhibitors, diuretics	CBC, CMP, lipid profile, urinalysis (annually) TSH once	EKG, Diagnostic echocardiogram	Nurse case management
Coronary Artery Disease (CAD)	Aspirin, statins, beta blockers	Lipid profile (annually)	EKG	Cardiac rehabilitation for post-myocardial infarction (MI) patients

Value-Based Services

Diagnosis	Medications	Labs	Imaging/Ancillary	Other
Dental Care, Preventive	Fluoride supplements (age 6 months to age 16), if indicated Professionally applied fluoride varnish (twice yearly in children aged 12 months to 16 years old who are at high risk), if indicated	None	Pit and fissure sealants in permanent molars of children and adolescents	None
Depression, Major in Adults (Severe Only)	SSRIs	None	None	Cognitive Behavioral Therapy (CBT) or Interpersonal Therapy (subject to limit, e.g. 10 per year) in conjunction with an antidepressant Medication management
Depression, Major in Children and Adolescents (Moderate to Severe)	None	None	None	Psychotherapy (CBT, interpersonal, or shorter term family therapy)
Diabetes – Type I	Insulin (NPH and regular only), insulin supplies, ace inhibitors	HgA1c (annually)	None	Diabetic retinal exam for adults (annually)
Diabetes – Type II	Metformin, sulfonyureas, ACE inhibitors, insulin (NPH and regular only), insulin supplies	HgA1c, lipid profile (annually)	None	Diabetic retinal exam for adults (annually)

Value-Based Services

Diagnosis	Medications	Labs	Imaging/Ancillary	Other
Hypertension	Diuretics, ACE inhibitors, Calcium channel blockers, Beta blockers	Fasting glucose, fasting lipids (annually)	None	None
Immunizations	Routine childhood and adult vaccinations	None	None	Follow ACIP recommendations for non-travel vaccinations
Maternity Care	Folic acid, Rh immunoglobulin (when indicated)	Screening for hepatitis B, Rh status, syphilis, chlamydia, HIV, iron deficiency anemia, asymptomatic bacteriuria, rubella immunity, screening for genetic disorders	None	None
Newborn Care	Ophthalmologic gonococcal prophylaxis, Vitamin K prophylaxis	Sickle cell, congenital hypothyroidism, PKU (cost borne by the state)	None	None
Reproductive Services	Condoms, combined oral contraceptives, intrauterine devices, vaginal rings, Implanon, progesterone injections, female sterilization, male sterilization	See STI screening and maternity care	None	None
Sexually Transmitted Infections	Syphilis – Penicillin IM or doxycycline Chlamydia – azithromycin or doxycycline Gonorrhea – ceftriaxone IM or cefixime po	In certain populations: chlamydia, gonorrhea, HIV, syphilis	None	According to USPSTF guidelines for appropriate populations to screen (A and B recommendations only)

Value-Based Services

Diagnosis	Medications	Labs	Imaging/Ancillary	Other
Tobacco Dependence	Nicotine replacement therapy, nortryptiline, and bupropion	None	None	None
Tuberculosis (TB)	Per CDC guidelines – standard drug treatment for latent and active TB	Screening and diagnostic algorithm according to CDC guidelines	Chest x-ray per CDC guidelines	None

Guidelines based on empirical evidence (systematic reviews and health technology assessments), from trusted sources such as: ACIP, AHRQ, Cochrane Collaboration, CDC, OHSU Center for Evidence-Based Policy, NICE, NIH, Ontario, SIGN, USPSTF, WHO

General principles

For medications

- 1) Generics unless no equivalent available
- 2) Medications for ≤ \$4 per month are preferred to more expensive medications

Glossary

ACE: angiotension converting enzyme

ACIP: Advisory Committee on Immunization Practices

AHRQ: Agency for Healthcare Research and Quality

CBC: complete blood count

CDC: Centers for Disease Control and Prevention

CMP: complete metabolic panel

EKG: electrocardiogram

HgA1c: hemoglobin A1c

HIV: human immunodeficiency virus

IM: intramuscularly

LFTs: liver function tests

NICE: National Institute for Health and Clinical Excellence (England)

NIH: National Institutes of Health

OHSU: Oregon Health & Science University

PKU: phenoketonuria

SIGN: Scottish Intercollegiate Guidelines Network

SBIRT: screening, brief intervention, and referral to treatment

SSRIs: serotonin specific reuptake inhibitors

STI: sexually transmitted infection

TSH: thyroid stimulating hormone

USPSTF: US Preventive Services Taskforce

WHO: World Health Organization

Essential Health Benefits (EHB) Workgroup

Progress Update (May 21, 2012)

What is the EHB Workgroup?

The EHB Workgroup was established by Governor Kitzhaber for the purpose of recommending essential health benefits for Oregon's individual and small group market both inside and outside the Exchange as mandated by the Affordable Care Act. Because the selection will have far reaching effects on health care reform, the health insurance market, and the operations of the Oregon Health Insurance Exchange (ORHIX), the Oregon Health Policy Board (OHPB) and the ORHIX Board jointly chartered the EHB Workgroup. Workgroup members were announced on April 2, 2012 and include representatives from health plans, small businesses, advocates, providers, agents, and other stakeholders. The Workgroup also includes one member of both the ORHIX Board and the OHPB.

How will EHBs be determined?

In December 2011, the United States Department of Health and Human Services (HHS) released a bulletin outlining that EHBs include ten statutory categories and be defined using a benchmark approach reflecting a "typical employer plan." The EHB Workgroup is chartered to recommend one of the selected EHB benchmark plans. Once a recommendation is finalized, the ORHIX Board and the OHPB must approve the recommendation and forward it to the Governor for communication to the HHS. For more information, refer to the EHB website at www.oregon.gov/OHA/OHPR/EHB/index.shtml.

What has the Workgroup accomplished?

On April 16, 2012, the first EHB Workgroup meeting was conducted and included an overview of the EHB process and expectations of the Workgroup. The second meeting was conducted on May 16, 2012 and Workgroup members were presented with a benchmark plan analysis prepared by Wakely, an actuarial consulting firm assisting with this process. Workgroup members were also provided with information on the related SB 91 (2011) process involving the determination of actuarial value for metal plans (e.g., platinum, gold, silver, and bronze). At the conclusion of the second meeting, the benchmark plan options were consolidated from ten plans to six plans as the EHB Workgroup eliminated the three federal plans and one of the state employee plans which was the Providence Statewide benchmark plan.

What are the next steps?

At the next EHB Workgroup meeting is scheduled for May 30th in Wilsonville and will further narrow down amidst the benchmark options, understand the impact of required supplemental benefits if a choice doesn't contain it (e.g. pediatric dental and vision) and hopefully result in getting closer to a preliminary recommendation. Preliminary recommendations will be posted for public comment which will be brought back to the Workgroup at their final meeting scheduled for June 22, 2012 for consideration in their final recommendation. The final recommendation will be presented to the ORHIX Board and the OHPB at a joint meeting on August 14, 2012.

Is there opportunity for public comment?

All EHB Workgroup meetings are open for the public to attend. However, public comment or testimony will be limited to 15 minutes at the end of each meeting. Due to the time limitations, individuals can also submit public comment or testimony by visiting the EHB Workgroup website or submitting it to staff. More information is available at: www.oregon.gov/OHA/OHPR/EHB/index.shtml. Public comment and testimony are also welcome at the Oregon Health Policy Board's (OHPB) and the Oregon Health Exchange (ORHIX) Board's monthly meetings or through their respective public comment processes, and will be shared with the Workgroup as they develop their recommendation, and to the Boards for their consideration prior to the August joint meeting.

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Health Information Technology Oversight Council

OHA Director's Report, May 4, 2012

Below is a summary of Health Information Technology Council (HITOC) and related workgroups, panels, and stakeholder meetings from April 4, 2012 through May 3, 2012. Full meeting summaries are available on the HITOC website at: <http://www.oregon.gov/OHA/OHPR/HITOC/index.shtml>.

April 5, 2012, HITOC: Members participated in a demonstration of CareAccord Direct Secure Messaging services, and received an update on the service implementation. Members discussed the recommendations of the Consent Implementation Subcommittee regarding meaningful choice of patients for the exchange of their individually identifiable health information through HIE. Given federal ambiguities and developing CCO needs, the recommendation is to not create additional consent requirements beyond what is already required by federal law, and that the issue should be revisited in the future. HITOC members continued their discussion of Oregon's Strategic Plan for HIT (OSP-HIT), agreeing on the criteria that should be used to identify and prioritize which barriers and strategic options should be included in the plan. In order to optimize time and resources, input and opinions on barriers and strategic options for telehealth, HIE, and electronic health records (EHR) will be gathered via electronic survey, the results of which will be distributed at next month's HITOC meeting.

May 3, 2012, HITOC:

Members expressed an interest in more structured communication with the Health Policy Board (HPB). It was agreed that a letter would be drafted and reviewed by HITOC members to request a more formal interaction between HITOC and the HPB. Members continued their discussion of the telehealth, HIE and electronic health record (EHR) components of Oregon's Strategic Plan for HIT. In addition to considering strategies and barriers, members talked about processes for further development of the Plan. O-HITEC provided an update on its work to assist providers in adoption and meaningful use of EHRs. HITOC members began a discussion of the health analytics component of OSP-HIT, which will be continued in a webinar prior to the June HITOC meeting. Points raised during the discussion included the need for information to be accessible to those who need it; the importance of identifying strategic options for the next three to five years; the current lack of tools for extracting information and presenting it in a useful way; the importance of measure selection; and challenges around where data is aggregated, especially for CCOs. Members also talked about a need to revisit the federated model within the Oregon Strategic Plan for HIE in light of the fact that regional HIEs have not developed as anticipated.

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Oregon

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May 15, 2012

Eric Parsons, Chair
Oregon Health Policy Board

Dear Mr. Parsons,

As you know, Oregon's Health Information Technology Council (HITOC) was established at the same time as the Health Policy Board through HB 2009. Since then, HITOC has spent most of its efforts focused on the planning work necessary to provide statewide health information exchange (HIE) services through Oregon's HIE Cooperative Agreement with our federal partners. Recently that work has moved from the planning to the implementation phase with the launch of CareAccord in April, 2012.

Now that this important HIE milestone has been reached, HITOC has begun to broaden its focus to a wider spectrum of health IT-related issues including responding to the Health Policy Board's request for advice and input on CCO criteria, and to HITOC's statutory duty of "develop[ing] a strategic health information technology plan for this state." HITOC plans to continue to update the Health Policy Board by submitting monthly summary reports, but given the interdependencies upon the foundational information technologies required for the success of Oregon's health system transformation, we would like to establish regular and more robust communication channels.

HITOC believes that health IT infrastructure and the policies to govern, protect, and support the security and viability of technology systems and the information within those systems will be critical components of health system transformation. In order to ensure the Health Policy Board remains fully informed on all health IT-related issues and so that all future efforts are aligned to the greatest extent possible, HITOC would like to offer a representative to be present regularly at Health Policy Board meetings to provide information or to listen to your deliberations and bring questions back to HITOC. Correspondingly, HITOC would welcome a similar representative from the Health Policy Board, either staff or board member as appropriate, to be present regularly at HITOC meetings.

Please let me know if the Health Policy Board would be interested in discussing options to enhance our interactions going forward.

Sincerely,

A handwritten signature in blue ink, consisting of several overlapping loops and a long horizontal stroke extending to the right.

Steve Gordon, MD
Chair, Health Information Technology Oversight Council
(on behalf of HITOC)